CENTER FOR MEDICARE & MEDICAID SERVICES
Centers for Medicare & Medicaid Services
Stakeholder Conference Call: Innovation Center Update
Moderator: Natalie Highsmith
March 21, 2011
3:00 p.m. ET

Operator: Good afternoon. My name is Danny, and I will be your conference operator today. At this time I would like to welcome everyone to the update on Innovation Center Conference Call. All lines have been placed on mute to prevent any background noise. After the speaker's remarks there will be a question and answer session. If you would like to ask a question during this time simply press star then the number one on your telephone keypad. If you would like to withdraw your question, please press the pound key.

Thank you. Natalie Highsmith, you may begin your conference.

Natalie Highsmith: Thank you, Danny. And welcome everyone to today's stakeholder call on the launching of the Innovations.cms.gov web site. We hope that you have gone on the web site and looked around, and have a chance to give us any feedback for the web site.

I just wanted to give a reminder that this call is not for press. So we will not be taking questions from the press, and we will direct you to our CMS press shop for your questions. And this call is just for background information purposes.

I will now turn the call over to Mr. Rick Gilfillan, who is the Acting Director of the Center for Medicare and Medicaid Services Innovation Center.

Rick Gilfillan: Thank you very much. And thanks to all of you who are on the lines today. We are excited to have this opportunity to be with you, on this day when we're launching our new web site. And we're looking forward to an opportunity to talk with you a little bit about the Innovation Center, the work that we are doing together with you all. And have a chance to get some feedback and have a discussion about the Innovation Center.

I'd first like to introduce two of my colleagues. Peter Lee and Julie Boughn. Peter is the Deputy Director for Policy and Program here at the Center. Julie is the Deputy Director for Operations. My name is Rick Gilfillan, and I am the Director of the Center. And I just want to give you a little bit of background on me. And Pete and Julie will do the same.

I am a family practitioner by background. Practiced for about 10 years. Eventually found my way into Medical Director activities for managed care companies. Did that for a number of years. And then eventually became the CEO and General Manager of several health plans. Most recently, I worked for the Geisinger Health System for the last five years, where I was the – or the first four years, the President of the health plan. And worked closely with our system physicians and hospital leaders on a number of new programs, intended to improve the quality and outcomes of care that we were providing.

For the last six months, I have been here at CMS. For the first six weeks I was the head of the group that was working on ACOs and value-based payment. And for the last five months have been the Acting Director here in the Center for Innovation.

Peter, would you like to introduce yourself?

Peter Lee: I would. Thank you very much, Rick. And it's also a pleasure to be having this conversation. And it's a great pleasure to be joining the Center in the role as Deputy Director of Policy and Programs. I know many of you in different settings that I have been in, most recently, for the last 10 months I have been the director of delivery system reform for HHS's Office of Health Reform, working on implementing the Affordable Care Act, making sure that its implementation touches not only all parts of the federal partners, but reaches the private sector to clinicians, to health plans, to employers.

And we're excited today. You may know that we also released a National Quality Strategy. One of the things that I was able to work on over the last 10 months. But prior to joining the administration, I was the CEO and then the Executive Director for National Health Policy for the Pacific Business group

on Health, where I worked with large public and private sector purchasers to work to improve healthcare, both in California, but also nationally.

Prior to that my other work-related activities were anchored to the consumer side, working as the Executive Director of the Center for Healthcare rights in Los Angeles. And prior to that on AIDS issues here in Washington, the National Aids Network.

It's a real privilege to be continuing that path of work now in the Innovation Center with a great cast of characters you'll be hearing more about. But I'll turn it right now to Julie Boughn. Julie.

Julie Boughn: Thank you, Peter. I guess third in line in the cast of characters with the Innovation Center. So I am the counterpoint to the two points that you just heard about. People with lots of private sector experience in healthcare. I'm the one with 25 years of experience with the federal government. Most recently up until this past December when I joined the Innovation Center was the Chief Information Officer for CMS, and the Head of our Office of Information Services. I job which I loved.

And but it's a very big privilege to be able to serve with the Innovation Center as we get started with our work. The one thing I wanted to make sure to say is though I was the Chief Information Officer, and I certainly have a background in Information Technology, I do not consider IT to be strength. I think some of my strengths are in making sure that big programs get delivered when they need to get delivered. So in my background there is a little program called Medicare Part D that I was heavily involved with.

Making sure that got implemented, as well as financial management of large programs, doing the budgets and acquisitions and procurements. And so I think one of the big roles I'll be playing with the Innovation Center is making sure we actually deliver on what we say we're going to deliver.

And then lastly, I have a passion for organizational development. And I'll be talking a little bit more about that later in the call. Back to you, Rick.

Rick Gilfillan: Thank you, Julie. One other person I want to mention who is on our team now is Joe McCannon. Joe is running our Learning and Diffusion activity. And Joe, as many of you may know was formerly with IHI, where he ran the 100,000 Lives campaign, is among the world's leaders in large scale change campaign. So we're very happy to have Joe with us. And we are in the process of adding a number of other leaders from around the healthcare industry to our team. We will be posting that information regularly on our web site.

Let me just then take a moment and talk a little bit about the opportunity that we see before us in our charge. Many of you know, I am sure, that the Center was created in the Affordable Care Act with an exclusive charge to create new models of care and payment that improve expenditures for Medicare, Medicaid, and CHIP beneficiaries. And at the same time, maintain or improve the quality of care for those beneficiaries.

That's a pretty explicit message about what is expected of the Center. And we will keep that mission squarely in our sights. And I also wanted to mention the mission for CMS as it's evolved under the leadership of (Don Burwick) and Secretary (Sebelius) over the last several months. That mission is to be a constructive force and trustworthy partner for continuous improvement in health and healthcare for all Americans.

We see the Center as being quite an integral part of that mission. Because if you think about a constructive force, and a trustworthy partner, what we're interested in is working with people in the delivery system. People who are advocates for patients. People who are interested in healthcare in general, to take a system that has been wonderful for many, and provide a wonderful care for many people over many years, and is made up of many individuals who are very hardworking and committed to providing outstanding care, but is – has continued to be somewhat fragmented.

And as it turns out, unsustainable from the standpoint of total cost of care that we're facing for healthcare. Our goal then is to drive continuous improvement towards the new system that provides a safer more seamless coordinated care

experience that hopefully will be sustainable, and will result in improved outcomes and lower cost over the coming years.

That's our mission. That's our vision, if you will. And we know that innovation is a critical part of that. We know that there is plenty of innovation in healthcare today. Medical entrepreneurs and innovators drive continuous improvement in therapeutic and diagnostic technology and techniques. Pharmaceuticals, medical devices. And many of these have driven rapid advancement in medical care and improved health for all Americans.

There's no shortage of innovation in healthcare in America. The establishment of the Innovation Center at CMS however, gives us a new target for innovation. It gives us the need – the requirement – the expectation that we will create and drive and support innovation that delivers that healthcare system of the future. We will measure our success along the road to that new healthcare system by looking at three aims.

One, better healthcare. We know we want to improve the individual patient experience of care. Along the Institute of Medicine's six domains of quality. They would be safety, effective patient centers, timely, efficient, and equitable care.

Secondly, we know we want to drive better health. And we want to see better health for entire populations. And we see this as addressing underlying causes of poor health such as physical inactivity, behavioral risk factors, lack of preventative care, obesity, et cetera.

And third, we know we need to lower the total cost of care to decrease the monthly expenditures for each Medicare, Medicaid, or (inaudible) beneficiary over time. And we will do this by continuously improving care. We will look for models of care, and models of payment that help healthcare providers deliver these three key aims. We believe that there are many models across the country that can achieve better outcomes and improve the quality of care and reduce cost over time.

Over the last four months we have talked to many individuals, over 4,000. We have had Open Door sessions, listening sessions, traveled around the

country, and seen multiple examples of models of care that deliver better outcomes at reduced cost. Our job in the Innovation Center will be to identify, validate, and scale these models of care to provide all beneficiaries with this safer, seamless care experience, better health and lower costs over time.

We believe that working together and supporting you all, people who are similarly driven to provide those outcomes for our outpatients, and our fellow Americans, that we can create a system that works better for everyone.

Julie, could you now tell us – tell the audience a little bit about our values and our work?

Julie Boughn: Sure thing. Thank you, Rick. So Rick slightly talked a little bit about the aims, the overall aims of the Innovation Center. And as I mentioned earlier, I joined the Center myself in December, late December. And I – we're going to start trying to keep track of what employee number we are. Because I was something under 20 as far as the numbers of employees in the Center.

Since then, we have been working very hard to build our team. And we're a combination – will be a combination of some employees that we wanted to have from CMS as well as some from the outside. And we're working around a set of values that we've been developing.

And I think I'll focus on a few of these, just a few of these. But first value is person and family-centeredness. And we mean this both obviously for ourselves as an employer. But it's really around all of the work that we're doing. Rick is very quick to point out to us why – you know why would the patient care? Or how is this going to impact the patient, when we start talking about the work that we have been doing.

We're going to be meticulously devoted to the results of the work that we have, as opposed to process measures. So we'll be focused very, very hard on that as we go about our work.

We're going to be looking to be as quick and agile as a federal agency possibly can be. And believe it or not, there are going to be ways that we can

work very quickly. And I think that today's call and what we're going to be talking about today are some examples of that.

And we're going to be an organization that with our stakeholder community is devoted to continuous learning. Learning from each other, sharing what we have learned with each other. And being as open and transparent as possible as we go about this very important work.

Now the way we're organizing the Center is very much around the description of the aims that Rick just told you about. And so we're going to have three kind of primary program groups where we're referring to them as. And it will be hard for me to talk about these program groups without talking about my favorite Medicare beneficiary, who is my 94-year-old grandmother, Mary Alice.

But the first group that we're going to be organizing around is patient care models. And so you can think of these models that we'll be testing, and hopefully scaling that are really focused on getting the right pair at the right time to the patient in the right settings. Every single time.

And so that's really what the patient care models are about. And so my grandmother won't unnecessarily go to an emergency room when we could have handled whatever her issue is you know actually in her apartment, which is one of the things that we did yesterday.

The next kind of focus that we'll have as a Center and as we organize our work is around seamless and coordinated care models. I mean this is going to be focused on improving health outcomes for patients, really as they continue across the care continuum. And so going back to my grandmother's little story. About two years ago she had an incident with a fractured hip. And went from surgical acute care hospital to a rehab hospital, to another acute care hospital, and back into a rehab hospital.

And we want to make sure that when patients have those kinds of care, or need those kinds of care that that happens in a smooth and effective and efficient way for all patients. Not just my grandmother.

And then lastly, the models, the way we'll be organizing around our program groups is around looking at models of care focused on the community and populations. And this is really about getting overall better health outcomes from the dollars that we spend on healthcare, and focused on keeping families and communities healthy, or at least as healthy as they can possibly be.

And so that's kind of our theme as we're organizing our work, and as we're getting set to take off as a Center. And along with that, we have been working on some of the processes that we'll be using to inform the Innovation Center's portfolio. And Peter is going to tell you about those.

Peter Lee: Great. Julie, thank you very much. And what I am going to run through is at a very high level, sort of our standard process of what our portfolio is. And for those of you that had the opportunity to look at the web site, this is under the section on About Us, as well as about our process.

And the main thing that I would not is that in all of our work, we're anchored in the reality that innovation comes from the community. Innovation comes from clinicians working with patients in new ways to address those three-part aims that (Rick) noted.

Our standard process is going to run through four basic steps. The first is, we're going to be soliciting ideas for new models, for ideas from the field. And when we talk about models, we mean potential changes in payment. But also changes in how care is delivered in ways that delivers better quality, higher value care to Medicare beneficiaries, Medicaid beneficiaries, CHIP beneficiaries.

We'll do that through Open Door Forums, listening sessions. But we'll also do it through our web site. And we encourage you to use the web site to submit your ideas, thoughts on – that will then be part of the process that we'll engage in, to review the range of ideas to select potential models that show high promise for meeting those three-part aims.

We'll engage stakeholders, consumers, patient groups, clinicians, hospitals, health plans, in flushing out the models to then go through what would

normally be a competitive bid process to have people from across the country to apply to participate as partners with the Innovation Center.

In that partnering, it might be a test that will run six months. It might be a year. It might be two years. During that time, we'll be working with partners to do testing of the models with rigorous evaluation that is going to be rapid cycle to look at what the lessons we can learn right out of the gate. We will be actively looking at models that as we implement them, that if they need to be modified, because we learn something from three pilots that isn't learned by the others, we'll take those lessons and try improve all of the systems that we're testing.

If a pilot has shown that it doesn't work, we'll be ready to terminate things. We're going to be doing rapid cycle evaluation to learn as we go.

Finally, after the evaluated models, we're going to be looking to expand and spread those models that are successful. And Rick noted, what does success mean? It means that it delivers better quality care, better health at lower cost through improvement. Where that's been shown, one way to take these to scale is for the Secretary to say, these are going to be part of the entire Medicare program. For a particular period of time. But it can be spread through - we will make it through the entire Medicare, Medicaid, or CHIP program.

But the spread will also happen, we believe through the private sector, through health plans through clinicians that we have partnered with. Learning from us and saying, we're going to run this out throughout the country in our efforts. Not through federal efforts. So we think spread is going to happen through both routes.

I am going to very briefly touch on two things that you can read about much more on the web site. The first is our Portfolio Criteria is, we are going to have, as we grow, a wide ranging portfolio addressing better healthcare and reduced costs, in terms of how to touch Medicare and Medicaid beneficiary? How does it address areas of greatest need? How do they address priority areas? Identify the National Quality Strategy?

A whole range of factors. I again encourage you to look at the web site. You can download a PDF that goes to these factors in more detail. But the key thing to think about when you look at our portfolio is, we don't think that any one model that we're going to test will address everything in the portfolio. Rather, we're going to have dozens of models that across them will make sure that we're addressing models that address rural communities as well as urban communities.

We'll have models that address the whole range of clinician types and different settings of care, that address short-term results that we can find out answers in a year, and others that we know are going to take three to five years. But the important thing to think about, a portfolio is going to be a mix of those factors. We encourage you to look at those portfolio factors and give us your input.

The other thing that I would note in terms of how we consider ideas, and you'll find this in the section of the website that is where we ask for your input on ideas, is how we actually consider specific ideas. What do we consider is a good idea? And we're going to be a very evidence-based shop. We're going to want to hear it from you on what's the evidence that this model actually makes a difference in the lives of beneficiaries?

(Inaudible) a touch in what ways? What's the hypothesis for change in terms of this model? Why do we think this is going to make a difference, and what's the evidence that supports it. And how big of a test did we undertake? So I would encourage you all to look at the material we have laid out as the ways we're assessing ideas. Give us ideas both on models that we should test, but also on the criteria we are using. And again, this is going to be an ongoing and very much a partnership process. And throughout this, we need your ideas.

So with that, I'll turn it back to Rick, to talk about our role as a partner. Rick?

Rick Gilfillan: Thank you, Peter. And I think this is – this is – as Peter – Peter touched on this already. But one essential point here is we are interested in being

partners. And the reality is we cannot change healthcare. Only people delivering healthcare can really change it. And to get us where we need to go.

So we are interested in partnerships with doctors, hospitals, nurses, home healthcare providers. Other DME providers, anyone out there operating in the healthcare system, we want to work with you. And the goal is going to be together, to find the new – these new models of care, new ways of delivering services that will deliver the outcomes that we are after.

On the web site, you'll see specific questions as Peter mentioned that get at the kinds of models we're after, as well as ideas about how we can operate the Center in a way that is most effective. We're interested in your thoughts on both. I'll thank you in advance for your contributions to the Center, your interest in our work, and our work together, and in your – thank you, for your commitment to improving our healthcare system.

So with that, let me open it up for questions.

Natalie Highsmith: OK, Danny, if you can just remind folks on how they can get into the queue to ask their question or give their comment. And everyone please remember, when it is your turn to restate your name, and what organization you are representing today.

Operator: At this time, I would like to remind everyone, in order to ask a question please press star then the number one on your telephone keypad. We'll pause for just a moment to compile the Q&A roster. Our first question comes from the line of (Andrew Cosky) from Home Healthcare. Your line is now open.

Andrew Cosky: Yes, thank you. Andrew Cosky with the Homecare Association of New York State. I know a couple of months ago you posted a funding, like an RFP on the web site. And I am wondering what we can expect in the next few months. Like which type of proposals may come out there with funding?

Peter Lee: Thank you very much for that question. This is Peter Lee. In the coming months, there is going to be a number of RFPs. And since we're in development, I won't note the specifics coming out. Some you might not be surprised by though. I'd note a couple of the things we're considering looking

very actively at include issues such as ACOs, accountable care organizations. Further development around medical homes, as we have a very deep interest in addressing issues of dual eligibles of the Medicaid populations in particular.

Those with multiple chronic conditions. We have a very strong interest in looking at programs that relate to bundles and bundling of care and services. And we're also looking very actively at programs that look at population health. I'd note that when you look at the National Quality Strategy it calls out in particular concerns around cardiovascular disease. It's one of the things we're charged to look at, and we're looking at very actively.

So I'd note though that these are potential areas, another that I would note again, I encourage folks that have joined this call, clearly your folks would care deeply about the whole agenda of changing healthcare in America. If you haven't finished reading it yet, please do read the National Strategy for Quality Improvement Healthcare that came out today that identifies six priority areas that the Center for Innovation will be focusing on.

The first one of those is improving care and making care safer, and addressing patient safety issues. It includes cardiovascular disease et cetera. So that would be a pretty good guidepost for you. But again, as Rick noted, we welcome your comments and thoughts on issues that we should have right out of the gate, or early out of the gate.

Andrew Cosky: Thank you.

Operator: Again, if you would like to ask a question, please press star then the number one on your telephone keypad. Our next question comes from the line of Jodi Hoffman from Westler & Walker. Your line is now open.

Jodi Hoffman: Hi, this is Jodi Hoffman with Westler & Walker. I just want to say thank you. It is terrific, and so nice to have this web site up and running and to have this conference call. It's very exciting for those of us who are out here trying to work on some system reform proposals, and options throughout the country.

I just wanted to note that it was really terrific to see the community and population based component. But there are some sections of the web site that

leave home health and home-based care (off) the list. And as you know, there is the Independence at Home pilot that you all are working on at CMS. And the VA does have its prime – it's home-based primary care program.

All of which I think are directly in line with right care to the right patient at the right time. So I guess that you might want to address that when you revise your web site.

Rick Gilfillan: Jodi, thanks very much. And we appreciate that. And we'll duly note your point. I should add – one other area that you know is – two areas, actually. As you point out that are of great interest. One is, the community at home initiative. And the other is looking at transitions of care and readmissions. So these again are areas of focus, and will be areas of focus for us. And I am sure will be areas of interest for home healthcare providers.

Operator: Our next question comes from the line of Joann Handy from Dido Services of California. Your line is now open.

Joann Handy: Yes. It's Aging Services of California. Can you talk about how the CMS initiative on care transitions that you just mentioned is going to intersect with the Innovation Center? I mean for example, the – I know there is an RFP that is due out any day now from the transition center. How does that fit in with what you are going to be doing? Because it could be considered a patient care model under your areas of focus. But I think it has a separate center at CMS. Is that correct?

Rick Gilfillan: As we are bringing this – the Innovation Center up, we have also been working very closely with our colleagues in the ORDI unit of CMS that has traditionally done demonstrations. And we have recently brought the two organizations together to work very closely so that we coordinate these – all of the various pilot and demonstration projects.

The transitions part you mentioned does indeed have separate authorization and funding under the Affordable Care Act. And we will continue to maintain different – appropriately I should say, maintain a distinction between the lines of authority and funding for those initiatives that traditionally have come

through the ORDI authorization process, and those that come through the Innovation Center process and authority.

And we are going to coordinate them so that from the delivery system side, it makes sense that we – you see us as a partner that is integrated and coordinated with you, and within our own shop. But those initiatives that are funded specifically under – and authorized under the Affordable Care Act will be managed appropriately given their – the origin of their funding and authorization.

Peter Lee: And let me – this is Peter. Let me build on Rick's answer. There is a – and it's a great question, Joann, is that we see the Innovation Center as a partner with many parts of both CMS as well as other parts of the federal government and the private sector. So there's efforts where the Innovation Center, such as some of our very early announcements of funding was to build on and support the Medicaid program's Health Home program. The funding for that is coming from Medicaid. But the Innovation Center can provide support for technical assistance, training, and support for the expansion of Health Homes that are going to be anchored in Medicaid.

Similarly, we're working very closely with HRSA and its support of federally qualified health centers, expanding their work around Health Homes and federally qualified health centers. So we're looking actively for ways to make sure that we aren't ever double spending resources, but getting the best resources and investment to deliver on the three-part aim.

And alongside that you know the compelling rationale for that coordination is because we want to be the partner of folks out there are doing the work and delivering care. And we want to prevent – present a kind of sensible ordinate look and support mechanism to you all in providing care. So it is critical for us to do that to coordinate internally, ever mindful of the realities of funding streams and the requirements for appropriate lines of authority to be followed.

Operator: Our next question comes from the line of Alan Kuzarney from Greater Newport. Your line is now open.

Alan Kuzarney: Yes. I have a question about the actual application process. We had sort of envisioned that CMS and the Innovation Center was going to have an actual application. I am now hearing there is going to be an RFP approach. We're specifically interested in the ACO model. And so can you describe how you apply to the Innovation Center to become ACO?

Rick Gilfillan: Yes, thanks, Alan, yes. We – the mechanisms that we use to develop relationships with innovators will vary by program. And I can't speak specifically to the ACO approach right now. Given where we are with the proposed rule, which will be coming out in the near future.

So I don't want to – I can't go too far into that other than to say in some instances there may be applications that are appropriate. In other instances, it may be an initial response to an RFP to be followed by selection. That – the specifics for any particular opportunity will be spelled out clearly on the web site, and there will be multiple options as we look at different models. Is that clear?

Alan Kuzarney: Yes. But we're still sort of in a holding pattern for right now.

Rick Gilfillan: Well as I say you know the – obviously we're all mindful of where we are vis-a-vis the ACO initiatives. So more news on that to come.

Alan Kuzarney: OK. Terrific.

Rick Gilfillan: You bet.

Operator: Our next question comes from the line of Alicia Kessey from California Hospital. Your line is now open.

Alicia Kessey: Hi, this is Alicia Kessey with the California Hospital Association. I greatly appreciate you all hosting this call, and want to applaud you and the staff for your tremendous outreach efforts to the provider community. I think many of us are really interested in sharing our ideas and to have a platform to do so is fantastic. And so we appreciate those efforts.

I think my questions are very much along the lines of what has just been discussed, about the coordination of the different offices within the administration, the application processes, and kind of after you submit your ideas, how is it that we're going to get feedback? How should we advise many of our members who are looking to share those ideas and really trying to find those right people to talk to within your organization?

Do you envision some sort of matrix or org chart that would kind of compliment the information that you have already provided on your web site that could assist us in identifying the way in which you have kind of – are trying to divide up, but also coordinate. So for example, Peter, when you said bundling, I am thinking about the acute post-acute bundle. But that's a demonstration. But should we be talking to folks in the demonstration office? Should we be talking to you, should we be talking to both?

Again, that would be really helpful from a – from an organizational perspective and a communications perspective if that type of information could be clearly articulated in a way that would help us in really streamlining our input in sharing that with you. And would welcome any thoughts or reactions.

Peter Lee: Alicia, it's a great both comment and suggestion. And a couple of things I'll note is that at this re-launch of the web site is version 2.0. And I think – and rapid cycle is going to be having 3.0, 4.0. One of the things we'll be having, or the sort of features we're thinking about having are having – I want to have a meeting. Here is what I want to talk about. Who do I meet with? A feature for that.

A feature to encourage dialog and discussion amongst innovators that may not be wanting to come and meet with us, but want to talk to one another, (inaudible) or doing something similar, and we can help do match making. And so the nearest term suggestion I would make, and I am really not just trying to punt it back to you. But, is in the section of the web site that talks about help us build the Center. We ask for what would help us help you?

So if you're saying boy, maybe a click on org charts idea. Give us those ideas. We'll take those and look at those as we build out what will be a much more rapid cycle as we're getting staffed up. Different versions of the web site to have ways for you to engage. Not just through you know submitting an idea. But sitting down and talking with the right people. Whether at the Center, you know or with other parts of HHS or CMS.

Alicia Kessey: Great thanks, Peter. We'll certainly send those ideas to you.

Rick Gilfillan: Yes, if I could just respond to one other point I think Alicia was making. And that is, the web site today, and as it evolves will be a great way for you to share ideas. So whether its bundling, and there may be ideas that you know are coming down the road in the future. But there may be activities that we want to pursue today. Because it makes sense around final payments or game sharing opportunities or whatever.

Those kinds – all those kind of initiatives will be considered as part of the Innovation Center work. So I would suggest again that you know err on the side of giving us more rather than less. And the Innovation – the web site will evolve. But right now, it's a fine place for us to capture your ideas. And we will, I think, over time give you more specifics on the organizational structure. And I will keep it updated with people within the Center as well.

We are not interested in hiding behind a web site. We are interested in you all know – we want to know you. We want you to know us. And we want to engage together as real partners, real people trying to do this work together.

Peter Lee: Rick will start hosting weekly potlucks at his place. Here on out.

Rick Gilfillan: Yes, right. Right. Yes. Right.

Operator: Our next question comes from the line of (Charles McLain) from (Philanthropy Now). Your line is now open.

Charles McLain: Hi, Rick, Julie, Peter. Thanks for this chance to input. And to be invited to the potluck. This question is really on behalf all our grandmother Mary Alice's. I am wondering, how might rigorous studies of the impact of patient

advocates, and secondly, the efficacy of complementary medicine interventions, how might they fit into your portfolio in terms of assessing quality of care, improvement, and cost reduction?

Rick Gilfillan: Well, that's a great question, Charles. You know we're after models of (inaudible). There are models of (inaudible) that involve you know different ways of providing care. And different ways of evaluating or addressing patient satisfaction and patient experience of care. We're very interested in that. I think the one point I would make is that you know think about it this way.

In general, if you want to think about a model of care that we would be interested in, think about patient needs. Think about a patient's needs that are going unmet or could be met better. Think about an intervention that addresses those needs for that patient and that population of patients. And then think about how can we see improvement as a result of this intervention that improves care, improves the experience of care, improves health, and impacts and reduces the total cost of care.

And tell us that story about your proposed intervention. So whether it's better paid, better patient's use of medications, a better care experience that somehow could have changed that patient's likelihood of going back to the hospital after admission, or a complimentary medicine type approach that you know might you think would tell a very different story in terms of the three dimensions.

We're interested in hearing about it. We're not going to be everything, and there are going to be other modes within the federal government and elsewhere that looks at you know very specific questions about technology or a drug or this (inaudible) the evidence of coverage approaches from CMS. But we are interested in hearing more rather than less. And if for some reason we feel a particular initiative doesn't quite match the scope of the Innovation Center, we will let people know that and circulate it if there is a more appropriate area of government for us.

Operator: Our next question comes from the line of Melucka Stole from Lee High Valley Health. Your line is now open.

Melucka Stole: Hi. Again, thanks to everybody for this call. And a lot of great information. This is Melucka Stole calling from Lehigh Valley. And this is a follow-up question to the ACO discussion, a few minute ago. And I guess just sort of a request that there was some discussion around exclusivity, that you couldn't be a part of a medical home pilot and then later on apply to be part of an ACO. So I think a lot of our primary care practices are really looking for help kind of getting to a certain point before they can form the basis for our ACO.

So I am sort of putting in a plea to that exclusivity won't apply.

Peter Lee: Yes, this is Peter. I think it's a great question. And it's one of the things that you are noted, which is a struggle that we won't have relative to evaluation. But it's a struggle we embrace is that we'll – and again, you'll need to see rules that come out. But the Innovation Center's philosophy is to encourage clinicians, provider organizations to be involved in multiple ways to change the delivery system.

And you know one could imagine a medical home that is a part of an ACO that is also tested a bundled payment system, while also having an exciting way to engage patient advocates in a new way. That's going to make evaluation tough for us. But that's how healthcare really works. And it's one of the things as a matter of philosophy we'll be looking for.

At the same time, we'll make sure a clinician doesn't get paid three times for the same service. And we'll look at that. But not in a way that would prohibit or discourage the most innovative folks to be innovative on multiple fronts at the same time. And again, it's an area that we know will be a challenge for our evaluators, which is why we're thrilled we'll have such a good evaluation team being built. Because it won't be easy. But we know that healthcare requires that sort of approach.

Melucka Stole: Great. Thank you.

Rick Gilfillan: One other point, if I could on that. And that is that I just want to make sure everyone is aware of the fact that we are working very closely together with Cindy Mann and her group in Medicaid, Melanie Bella, and her group on the Duals. And the dual eligible population. And Jon Blum and his group on the Medicare initiatives and Medicare population.

We are very consciously working on this specific issue as an example of the need for us to coordinate internally in a way that allows us to work externally in ways that reasonable. And so as Peter mentioned, we want to make sure we don't share the same savings twice or three times. But we also know we want to get – we want to create a wildfire of innovation out there, and we don't want to – there to be obstacles from people participating in different programs.

Melucka Stole: Great. Thank you.

Operator: Our next question comes from the line of Lisa Graburg from American Hospital Association. Your line is now open.

Lisa Graburg: My question has been asked and answered. Thank you.

Rick Gilfillan: Thank you.

Operator: Our next question comes from the line of Brian Gallagher from American Pharmacists Association. Your line is now open.

Brian Gallagher: Well given the national drug spend curb medication usage issues and the need to take medications correctly, would you comment on the plans for testing medication therapy management as required under the statute? Will MTM be baked into all the models involving medication? Or will it be standalone tests?

Rick Gilfillan: Yes, thank you very much for that question. And first, the issues of medication therapy management encouraging patients with tools information to take the right drugs at the right time, and to get the phenomenal important area of concern we're looking at very closely.

The one thing that I would note, which is important I think to understanding the legislation and how we operate within it is, for those that aren't familiar with the Affordable Care Act, which established the Center, identified 20 potential programs that we should look at as models we should consider. That is central and core father that we are looking at. As is, the rich suggestions we've received from the community in the last six months, and more ideas we're receiving. So that is an area that we're looking at very closely.

The other thing that I know and Brian knows well is, as Rick noted, when the Innovation Center works closely with the core other parts of CMF, Medicare, Medicaid, and the duals programs, there are provisions to – within the Part D benefit program coming down the track to establish Medicare – medications therapy management programs that are Part D requirements. And we'll be working very, very closely with the Center for Medicare as those roll out. So our efforts compliment those.

Brian Gallagher: OK.

Operator: Our next question comes from the line of Kathy Kuhlman from Luntra Healthcare. Your line is now open.

Kathy Kuhlman: Thanks, Lunetra Healthcare Solutions. People always get us mixed up with the sleeping pills. Anyway, thank you very much. I had a couple of questions. One, where are the 20 topics that you just mentioned listed? Are they on your web site? And number two, how will the Innovation Center be interfacing with, or differing from, or collaborating with the Arc Innovations Network and their Action Network? And number three, anything related to cancer screening and the priority topics? Thank you.

Rick Gilfillan: Great questions. Now a couple things. In the section of About Us, on our web site, you can click and link directly to the legislative authority under which the Center for Medicare and Medicaid Innovation was founded. In that legislation, there is a list of potential models described as opportunities that are suggestions for us to consider. And again, as I noted, those are a core part of what we are looking at and are considering very, very actively.

With regard to the AHRQ Innovation network, it's another really great question. Because I think one of the things that we recognize is that there is not just a wealth of activity in the community amongst our federal partners. There's been some very good work being done through AHRQ, through HRSA, through CDC that are seeking to promote innovation. And supported in a range of ways.

We're working closely with everyone one of those agencies. And how it's actually going to take shape, it's in development, and again, I'd welcome your thoughts and suggestions. You'll note, we actually link to the Arc innovation network on our web site. As we grow and develop those relations, we'll see how we can reinforce and support one another.

And you're last question related to I believe cancer therapy.

Kathy Kuhlman: Screening.

Rick Gilfillan: Pardon me?

Kathy Kuhlman: Cancer screening.

Rick Gilfillan: Cancer screening.

Kathy Kuhlman: And dual eligibles.

Rick Gilfillan: Cancer screening and dual eligibles. You're adding each (inaudible), Kathy. And again, quite honestly, I am not sure if we have a specific model we're looking at. If you have a model you think shows great opportunity around supporting better care, and it was – is a model that we should be testing or seeking if it should be replicated that relates to cancer screening for dual, bring it on. We welcome the suggestion.

Kathy Kuhlman: Thank you.

Rick Gilfillan: Thank you.

Operator: Our next question comes from the line of Diane Million from American Society of Eco-Cardiology. Your line is now open.

Diane Million: Thank you for that good effort. I guess my question relates to funding. And I was confused about whether and to what extent there is additional appropriations that will be necessary for Congress or the Innovation Center to do its work as mandated by the ACA?

Rick Gilfillan: Yes. Just to be – this is a question we often get. But I will – the $10 billion to support the Innovation Center's evaluation and work has been appropriated. It was appropriated when the Affordable Care Act was passed. It does not take any further acts of Congress to actually apportion fund. We go through processes with the Office of Management and Budget. But it would actually take an act of Congress, both houses of Congress and a signature of the president to take money back at this point.

So the support is there. It's already been appropriated.

Diane Million: Thank you.

Natalie Highsmith: OK, Danny, we have time for one final question.

Operator: Our final question comes from the line of Haru Hososephian from Medical School of California. Your line is now open.

Haru Hososephian: Hi. Thank you. Thank you for all the work you guys are doing. I am with the (inaudible) School of Medicine (USD). And I was just wondering, this (inaudible) is something that we're definitely very wary of up here in California, Los Angeles particularly. I was wondering if (inaudible) ACOs is something that's on the radar of (CMMI) or something that perhaps again we can have a conversation about. Thanks a lot.

Rick Gilfillan: Yes. I am sorry. I heard ACO, but I didn't hear the preface to that. What kinds of ACOs were you asking about? Was it something specific?

Haru Hososephian: About the ACO (inaudible) …

Rick Gilfillan: I am sorry. Yes.

Haru Hososephian: (inaudible)?

Rick Gilfillan: Yes. Sure. Thank you. I heard. I got that. Yes, we have heard a lot from people about that. I think it's an important topic. We're very sensitive to the issues for safety net providers. And we know that as we think about our work and as we document it in our values and in our criteria, we want to be mindful of making sure that as we go about our work that the most vulnerable populations are squarely in our view for testing and new models.

So we're very focused on that. We are looking, and will be over time coming forth with more information about that. And again, the – I think one next step in that regard, or one predicate is for the ACO rules, which were to be out and for people to start understanding that framing. So that will be coming out as I said, not too far in the future.

So it's on our radar screen. It's on our list. And we are actively at times talking with and thinking – talking with people about it.

Well let me just conclude by reminding everybody to be sure they sign up for our list-serve to stay connected to the Center and receive updates from the Center on new activities, opportunities, and initiatives. Thank you very much for being with us today. Thank you very much for all of you who are out there providing care for patients, advocacy for patients and their families, and generally working hard to make our healthcare system better.

We really look forward to having the opportunity to work with you. And we look forward to your contributions both in terms of potential models of care and ideas as to how we can be most effective in being that those trustworthy partners we talked about.

Thanks, and have a great day.

Operator: This concludes today's conference call. You may now disconnect.

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